Pathways to Value: Value Proposition for Total Population Health

2015 Flex Program Reverse Site Visit
Bethesda, MD
June 23, 2015

A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex Monitoring Team

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

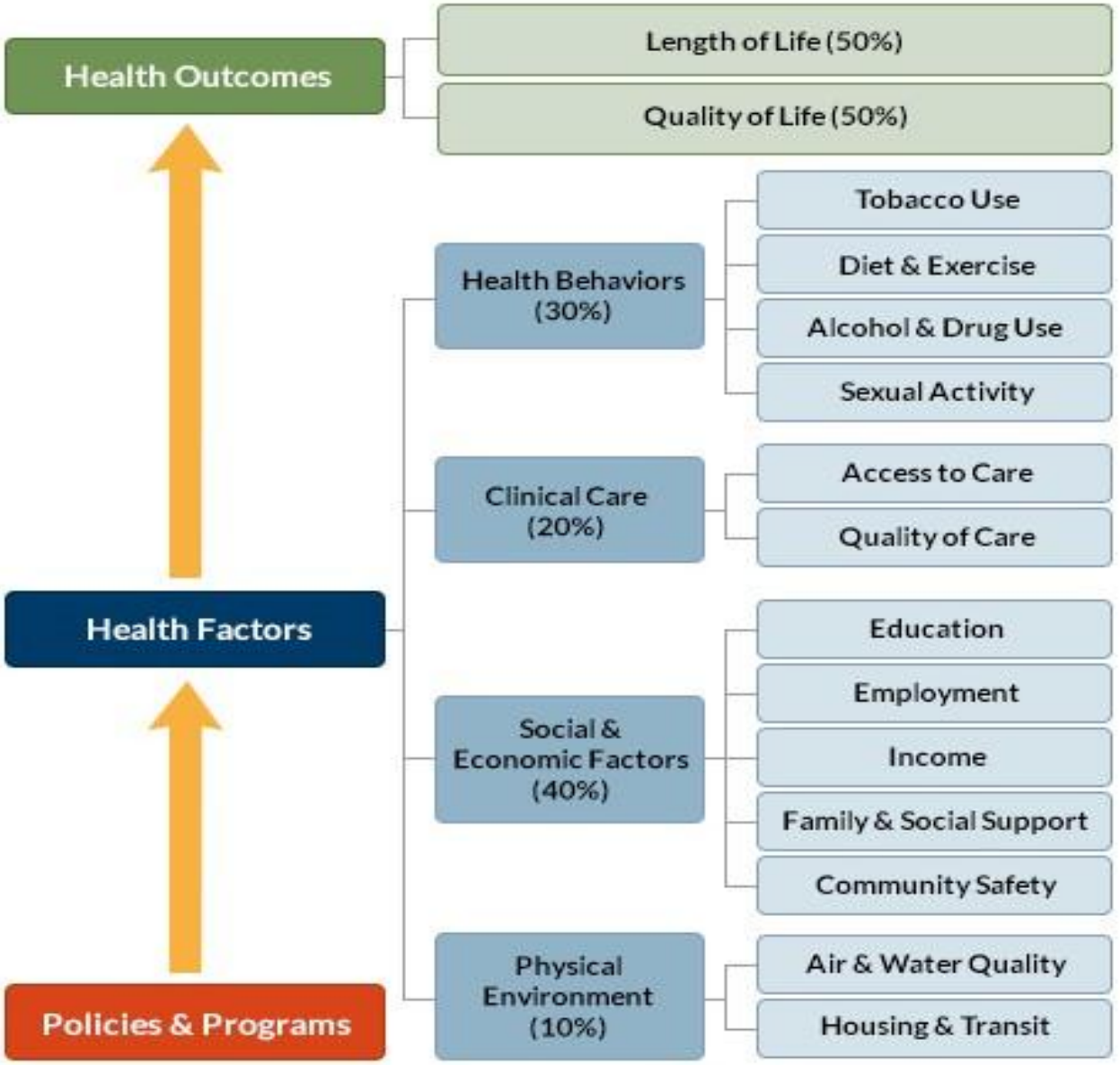
Thinking About Population Health

- Most common focus - Accountable Care Organization or health plan approach
  - Clinical/chronic disease outcomes of enrolled patients
- Less common focus - Accountable Health Communities or Total Population Health
  - Outcomes are driven by multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors
  - Makes many hospital boards and CEOs nervous

Reality of Total Population Health

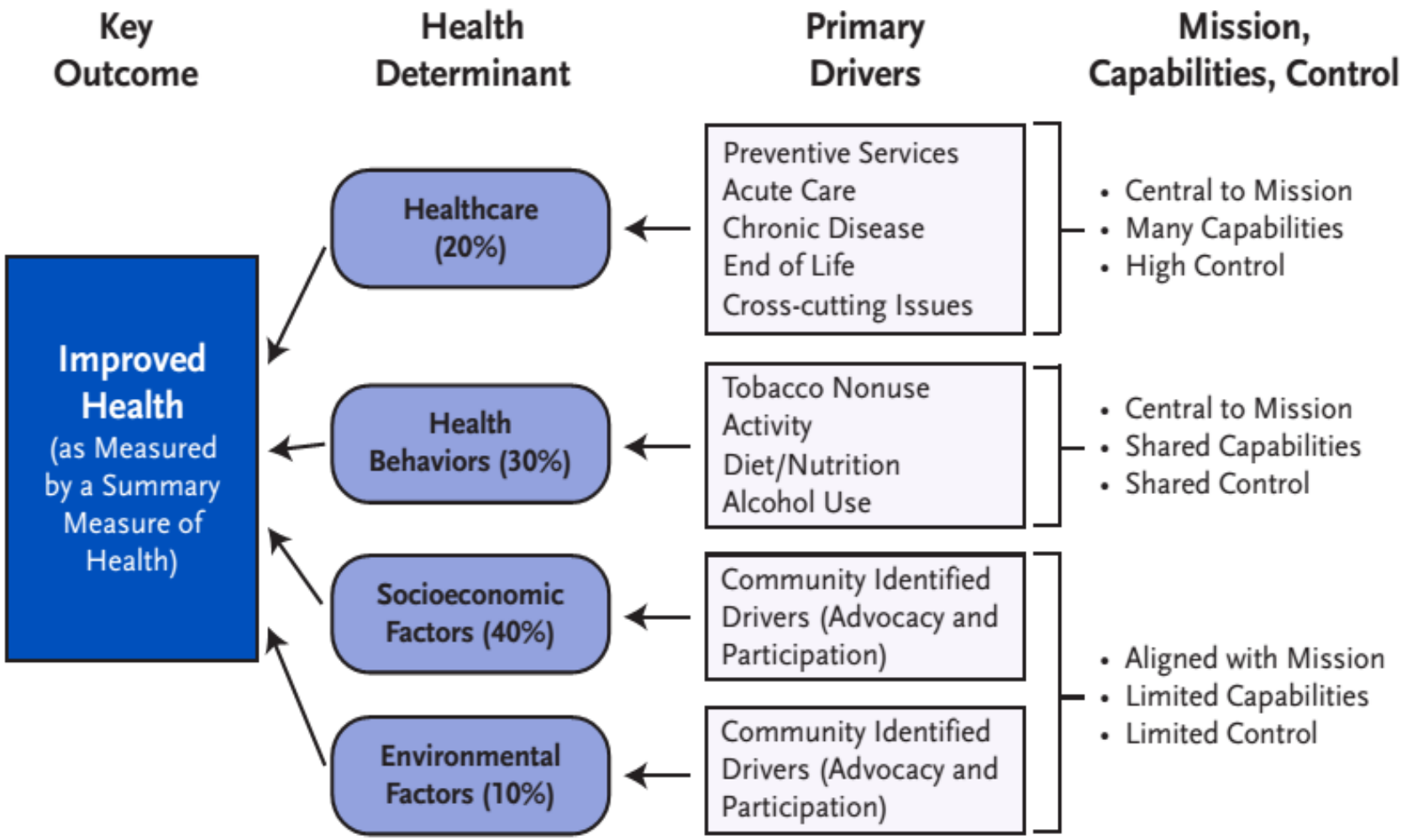
- No single entity is accountable
- Collective action by multisectoral partners is essential
- New structures, incentives and resources are needed
- Need to blend funding and resources
- Much of what impacts population health occurs outside of hospital and providers walls
- Population health is local – a function of community wellbeing and resourcefulness

Factors Affecting Health



Source: County Health Rankings, 2014

HealthPartners Health Driver Program



Source: Adapted from G. Isham and D. Zimmerman, presentation, HealthPartners Board of Directors Retreat, October 2010.

Value Proposition of Total Population Health

- Many hospital boards and administrators do not understand the value proposition for total population health
- Makes better use of limited resources
- Enforces important community role of hospital
- Reimbursement systems are moving in this direction
- Creates stronger partnerships and engagement with public and private sectors
- Shares responsibility for health improvement
- Can contribute to real improvements in the health of local residents
- It is the right thing to do

Leverage Existing Funding and Policies

- Clarify and improve accountability for community benefit from tax hospitals and, at the local level, public facilities
- Enforce existing laws and regulations promoting health
- Leverage purchasing power of the public and private sector
- Maximize enrollment in public programs
- Improve the efficiency and effectiveness of government programs
- Rely on the evidence to design and target policies and programs
- Expand wellness activities to government agencies and local businesses

Getting Started

- Develop local partnerships and leadership
- Target essential services needed within community
  - Mental health, primary care, long term care, prevention and wellness
- Develop program targeting hospital employees
  - Expand to local employers including governmental units
- Address needs of uninsured patients using system
  - Access to services, care management, links to primary care, revise financial eligibility standards to align with local needs

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Population Health Activities: Critical Access Hospitals

Leadership-Mt. Ascutney Hospital and Health Center

- Partnerships to support community health infrastructure
- Goal - address fragmented and decentralized care services
- 14 health promotions implemented, trust/collaboration improved
- Challenges – skepticism over control and management
- Long standing mission to promote the health and wellness of the community
- Activities funded over time by different grants
- Key factors-assessment/evaluation, community health metrics
- Create partnerships and give away credit, open communication, develop network and sense of partnership, decentralization

Measurement/Data-Fulton County Medical Center

- Implemented the Healthy Communities Dashboard – a tool that centralizes data and evidence based resources
- Supports needs assessment and community reporting
- Dashboard reflecting six priorities with community metrics
- Data shared with the community and other providers/agencies
- Used evidence based resources to identify interventions
- Monthly meetings of Fulton County Partnership (20 local agencies) to review priorities, outcomes and progress
- Working to develop data to “prove” and support outcomes

Mental Health-Essentia Health St. Mary's

- Collaborative Care Management of Depression in Primary Care
- Priority need identified in CHNA - initial funding with grant from Office of Rural Health
- Depression care within primary care setting - screens primary care patients using PHQ-9 by a team that includes a behavioral health specialist, a psychiatric nurse practitioner, and a care coordinator
- Coalition of EH-St. Mary's and community mental health professionals
- Community outreach and education

Addressing Determinants of Health - Wrangell

- Wrangell Alaska Medical Center-Rural Health Careers Initiative
- Partnered with local education programs to develop certified nursing assistant program – 1 year program
- Recognized the economic and social challenges of the community and the need for qualified nursing assistants
- Trained 200 students–Wrangell pays costs for employees
- Challenges – increasing community interest, improving educational performance
- Students receive mentoring and financial assistance
- WMC employs the majority of graduates

Cardiac Care-New Ulm Medical Center

- Heart of New Ulm Project applied evidence-based practices
- Reduce # of heart attacks in New Ulm over 10 years
- Collaboration with Minneapolis Heart Institute Foundation, local employers and local providers
- Results: Improvements in consumption of fruits and vegetables, taking daily aspirin, participation in exercise
- Success factors: clear vision, mission and values; culture of collaboration; clear goals and objectives; organizational structure; dedicated leadership; effective partnership operations; demonstrated outcomes and sustainability; and solid metrics for performance evaluation and improvement

Employee Wellness- Redington Fairview

- Redington Fairview General Hospital houses the Greater Somerset Public Health Collaborative
- Developed community-based employee wellness program for very small businesses
- Small businesses can offer workplace wellness activities that would not normally be economically feasible for groups their size (cost is $2.00 annually per employee)
- Environmental scan of the worksite, recommend policy and recommendations, assistance in developing policies, and workplace wellness toolkit

PCMH-Yuma Hospital District

- Worked with local safety net clinics to become PCMHs under a five year demonstration by Colorado Community Health Network
- Created teams to encourage transformation and work with clinics
- Led to invitation to participate in the Medicaid Regional Care Coordination Organization –pay for performance
- Targeted a pool of high risk people